

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02953

Reg. Dist. No. 292

1. PLACE OF DEATH:

County Waltham
City or town Oxford Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? life
Hospital, institution, or street address where death occurred: no
How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Waltham County Waltham
City or town Oxford Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. Market St.
(If rural, give LOCATION)
2.(a) If veteran, name war no

3. (a) FULL NAME

Calvin Bonks

3. (b) Social Security Number

no

4. Sex male 5. Color or race A.A. 6. (a) Single, married, widowed, or divorced Single
6.(b) Name of husband or wife no
6.(c) If alive, give age no years
7. Birth date of deceased (mo., day, yr.) Mar 16 1938
8. AGE: Years 8 Months 14 Days 17 If less than one day hrs. min.

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 30 19 46 at 3:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 30 19 46 to Mar 30 19 46
and that I last saw h. on Mar 30 19 46
Immediate cause of death The Pleurular
Nephritis

DURATION

6 wos

Due to Cholera Obscure
Other conditions Cholera

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op. None

Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide no Date of no
Where did injury occur? no (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
Means of injury no Injured at work? no

23. SIGNATURE P. Shewers M.D. or other

Address A. Michael Date signed 3.31.46

9. Birthplace Oxford Md
(Town, county, and state)
10. Usual occupation no
11. Industry or business no
12. Name William Pinder
13. Birthplace Oxford Md
14. Maiden name Arsela Wilson
15. Birthplace Oxford Md
16. Informant Arsela Wilson
Address Oxford Md
17. Burial Date thereof Apr 2-1946
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Odd Fellows
Location Oxford Md
18. Funeral director James Stewart
Address Dalshbury Md
19. april 46 Registrar
(Date read by registrar)

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 5 1946

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1600

CERTIFICATE OF DEATH

02954

Reg. Dist. No. 290

1. PLACE OF DEATH
County Talbot County
City or town Easton, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 1/2 hrs.
Hospital, institution, or street address where death occurred:
Memorial Hospital
How long in hospital or institution? 1 1/2 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Caroline
City or town Greensboro
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2.(a) If veteran, name war _____

3. (a) FULL NAME Frank Carroll
Baby Boy Dill

3. (b) Social Security Number

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced single

6. (b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.) March 13, 1946 6. (c) If alive, give age _____ years

8. AGE: Years _____ Months _____ Days _____ If less than one day 1 hrs. 30 min.

9. Birthplace Memorial Hospital Easton, Md.
(Town, county, and state)

10. Usual occupation _____

11. Industry or business _____

12. Name Earl Dill

13. Birthplace Dill

14. Maiden name Myrtle Dean

15. Birthplace Dill

16. Informant Earl Dill

Address Greensboro Md.

17. Burial Date thereof 3/13/46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Greensboro

Location Greensboro Md.

18. Funeral director Raymond B. Pawlings

Address Greensboro Md.

19. 3/13 46 N. St. Neer
(Date rec'd by registrar) 19 _____ Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-13 19 46 at 2 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar. 13 19 46 to Mar. 13 19 46 and that I last saw him alive on Mar. 13 19 46

Immediate cause of death _____ DURATION _____

Retained placenta

Due to _____

Due to abortion

Other conditions Cause not determined

(Include pregnancy within 8 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of Injury _____ Injured at work? _____

23. SIGNATURE W. B. Palmer M. D. or other _____

Address Sutton, Md. Date signed 3/13

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 29 1946

BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 22

CERTIFICATE OF DEATH

Reg. Dist. No. 294

1. PLACE OF DEATH:
 County... Calvert
 City or town... St. Michaels
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death... Life
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State... Calvert County...
 City or town... St. Michaels
 (If outside city or town limits, write RURAL and give nearest town)
 Street No...
 (If rural, give LOCATION)
 2.(a) If veteran, name war...

3. (a) FULL NAME James T. Prampton 3. (b) Social Security Number None

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, divorced Widowed

6.(b) Name of husband or wife Gertrude T. Prampton

7. Birth date of deceased (mo., day, yr.) 6-27-1860

8. AGE: 85 Years 9 Months 2 Days 0 hrs. 0 min.

9. Birthplace St. Michaels Md.
 (City, county, and state)

10. Usual occupation Farming

11. Industry or business Retired

12. Name Vincent T. Prampton

13. Birthplace Queen Anne's Co.

14. Maiden name Wilhelmina Melvin

15. Birthplace Greenboro Md.

16. Informant Mrs. Charles T. Prampton

Address St. Michaels Md.

17. Burial Date thereof 3-31-46
 (Burial, cremation, or removal. Which) (month) (day) (year)

Cemetery or crematory St. Michaels Methodist

Location St. Michaels Md.

18. Funeral director Wm. Marshall

Address St. Michaels

19. 3-31- 1946 G. Prampton
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 29, 1946 at 3:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 19, 1945 to March 29, 1946 and that I last saw him alive on March 28, 1946

Immediate cause of death Acute Atherosclerosis DURATION 2 yrs.

Due to Cholesterol heart disease 5 yrs.

Due to

Other conditions

(Include pregnancy within 6 months of death)

Major findings of operation... Date of op.

Autopsy results... PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Wm. Marshall M. D. or other
 Address St. Michaels Md. Date signed March 30, 1946

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
APR 9 1961
FBI - NEW YORK

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of year of birth of deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 95.2

02956

FILM No. 101 APR - 9 1946

CERTIFICATE OF DEATH



Reg. Dist. No. 99

1. PLACE OF DEATH

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex.....

5. Color or race.....

6. (a) Single, married, widowed, or divorced.....

6. (b) Name of husband or wife.....

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.).....

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace.....

(Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER

12. Name.....

13. Birthplace.....

14. Maiden name.....

15. Birthplace.....

16. Informant.....

Address.....

17.....

(Burial, cremation, or removal. Which?)

Date thereof.....

(month) (day) (year)

Cemetery or crematory.....

Location.....

18. Funeral director.....

Address.....

19.....

(Date rec'd by registrar)

19.....

46

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MEDICAL CERTIFICATION

20. DATE OF DEATH.....

March 23

19.....

46 at 4 P: M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 20

19.....

46 to March 23

19.....

46

and that I last saw him alive on March 23

19.....

46

Immediate cause of death.....

Acute Myocarditis

DURATION

29 mo.

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE.....

Harvard T. Walt, M.D.

M. D. or other

Address.....

Easton, Md.

Date signed.....

3/25/46

RECEIVED
MAR 27 1946
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02957

Reg. Dist. No. 296

1. PLACE OF DEATH:

County Calvert
 City or town Easton md
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death Two weeks
 Hospital, institution, or street address where death occurred Memorial Hospital
 How long in hospital or institution? Two weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State md County Calvert
 City or town Peddersley md
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. na
 (If rural, give LOCATION)
 2.(a) If veteran, name war na

3. (a) FULL NAME

Bertha Harris

3. (b) Social Security Number

na

4. Sex Female 5. Color or race col 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife George Harris
 7. Birth date of deceased (mo., day, yr.) Oct 1 about 1889
 8. AGE: Years 56 Months about Days 1 If less than one day hrs. min.

9. Birthplace Peddersley md
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Same as above

12. Name Washington Stanford

13. Birthplace Peddersley md

14. Maiden name Bernice Boyce

15. Birthplace Peddersley

16. Informant Ma Elsie Holman

Address Philadelphia

17. (Burial, cremation, or removal, Which?) Burial Date there March 18 1946
 (month) (day) (year)

Cemetery or crematory Easton

Location Hillsboro md

18. Funeral director James Stewart

Address Salisbury md

19. 3/15 19 46 M.D. Norris
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 13 19 46 at P.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 26 19 46 to March 13 19 46
 and that I last saw h. live on March 13 19 46
 Immediate cause of death

Diabetic Sanguine DURATION 4 weeks
 Due to Diabetes mellitus
 Due to
 Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Lap Amputation
 Date of op.

Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of Injury Injured at work?

23. SIGNATURE W. E. Cap m d M. D. or other
 Address Easton md Date signed 3-13-46

RECEIVED

MAR 26 1946

BUREAU V &

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03126

Reg. Dist. No. 290

1. PLACE OF DEATH:

County TalbotCity or town Easton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 hrs 23 min

Hospital, Institution, or street address where death occurred:

Memorial Hospital Easton

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Queen Anne'sCity or town Chester

(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Baby Girl Horner

3. (b) Social Security Number

4. Sex Female5. Color or race W6.(a) Single, married, widowed, or divorced No 26.(b) Name of husband or wife Robert Horner

6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) March 26 - 46

8. AGE: Years _____ Months _____ Days _____

It less than one day 9 hrs. 23 min.9. Birthplace Talbot - Easton, Md

(Town, county, and state)

10. Usual occupation _____

11. Industry or business _____

12. Name Robert Horner13. Birthplace Chester14. Maiden name Lois M. Jones15. Birthplace Chester, Md.16. Informant Mrs. C. R. HornerAddress Chester, Md.17. Married Date thereof March 27 1946

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory ChesterLocation Chester18. Funeral director Wm. E. Hummer, Inc.Address Easton, Md.19. 3/26 46 N. H. Morris

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 26 19 46 at 5:30 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 26 19 46 to Mar. 26 19 46and that I last saw her alive on Mar. 26 19 46Immediate cause of death Pneumonia

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE J. Izler Baker M.D.Address Easton, Md. Date signed 4/1

RECEIVED

APR 11 1946

BUREAU 3 6

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(31-2)

02958

CERTIFICATE OF DEATH

Reg. Dist. No. 291

1. PLACE OF DEATH

County Talbot
City or town St. Michaels
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County Talbot
City or town St. Michaels
(If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2. (a) if veteran, name war

3. (a) FULL NAME

Carrie L. Jackson

3. (b) Social Security Number

none

4. Sex Female 5. Color or race Colored 6. (a) Single, married, widowed, or divorced widow

6. (b) Name of husband or wife Thomas Jackson

7. Birth date of deceased (mo., day, yr.) Nov. 6, 1878 8. (c) If alive, give age years

8. AGE: Years 60 Months 4 Days 23 If less than one day hrs. min.

9. Birthplace St. Michaels
(Town, county, and state)

10. Usual occupation House wife

11. Industry or business

12. Name Thomas H. Bowman

13. Birthplace St. Michaels, Md

14. Maiden name Elizabeth Chase

15. Birthplace St. Michaels, Md

16. Informant Lillian J. Green

Address St. Michaels, Md

17. Burial Date thereof April 1, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Cemetery

Location St. Michaels, Md

18. Funeral director Newnam & Harrison

Address St. Michaels, Md

19. md 30 19 46 John H. Newnam
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 29, 1946 at 3 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 20, 1946 to Mar 29, 1946

and that I last saw him alive on Mar 28, 1946

Immediate cause of death Chute Arteriosclerosis

Due to Arteriosclerosis Nephritis

Due to Hypertension

Other conditions None

(Include pregnancy within 8 months of death)

Major findings of operations None

Date of op. ✓

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ✓ Date of ✓

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury ✓ Injured at work? ✓

23. SIGNATURE J. C. Shewers

Address St. Michaels, Md Date signed 3. 30 46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UNITED STATES DEPARTMENT OF JUSTICE

RECEIVED

RECEIVED

APR 3 1946

BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02959

Reg. Dist. No. 291

1. PLACE OF DEATH:

County TalbotCity or town St. Michaels
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Cornelia Baynard McQuay

3. (b) Social Security Number

none4. Sex female 5. Color or race white 6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife J. Richard McQuay6. (c) If alive, give age 71 years7. Birth date of deceased (mo., day, yr.) Mar. 30 18798. AGE: Years 66 Months 11 Days 28 If less than one day
.....hrs.min.9. Birthplace St. Michaels
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Samuel Baynard13. Birthplace Talbot Co. Md14. Maiden name Rebecca Lambdin15. Birthplace Talbot Co. Md16. Informant J. Richard McQuayAddress St. Michaels. Md17. Burial Date thereof Mar 30, 1946
(Burial, cremation, or removal, which?) (month) (day) (year)Cemetery or crematory Christ CemeteryLocation St. Michaels. Md18. Funeral director Newnam & HarrisonAddress St. Michaels Md19. Arch 29 19 46 John Hurwales
(Date rec'd by registrar) (month) (day) (year) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County TalbotCity or town St. Michaels
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH March 27, 1946 19..... at 10:30 P M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 5, 1946 19..... to March 27, 1946 19.....and that I last saw h. er Mar. 20, 1946 19.....Immediate cause of death
Mitral Disease
Hypertension

DURATION

1 yrDue to ✓Due to ✓Other conditions ✓

(Include pregnancy within 3 months of death)

Major findings of operations ✓Date of op. ✓Autopsy results ✓

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ✓ Date of ✓Where did injury occur? ✓
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) ✓Means of injury ✓ Injured at work? ✓23. SIGNATURE J. B. Lewis M.D.
St. Michaels, MdM. D. or other 3.29.46Address St. Michaels, Md Date signed 3.29.46

RECEIVED

APR 3 1946

BUREAU V S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 742

02960

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH

County Calvert
City or town Cardora
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? about 4 months
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Queen Anne's
City or town Centerville
(If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION) Home
2.(a) If veteran, name war

3. (a) FULL NAME

Travers Moore

3. (b) Social Security Number

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Male White Single

B.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) July 13 - 1898
B.(c) If alive, give age years

8. AGE: Years Months Days If less than one day
48 1 15 hrs. min.

9. Birthplace Centerville, Maryland
(Town, county, and state)

10. Usual occupation Painter

11. Industry or business House painting

12. Name Nathan H. Moore

13. Birthplace Delaware

14. Maiden name Rebecca E. Willis

15. Birthplace Caroline Co. Md

16. Informant Herbert W. Moore

Address Centerville Maryland

17. Burial Date thereof Mar 30. 46
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Chestfield

Location Centerville, Maryland

18. Funeral director Barton Bros

Address Centerville, Maryland

19. 3/29 19 46 N. H. Neer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28 19 46 at 7:24 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw him alive on 19

Immediate cause of death

Coronary occlusion Ischemic

Due to

Due to

Other conditions Chronic alcoholism years

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Louis J. Mitty Md. Dep Med M. D. or other

Address Barton Ind Date signed 3-29-46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED
APR 4 1946
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore Md.

CERTIFICATE OF DEATH

02961

Reg. Dist. No. 290

1. PLACE OF DEATH:

County Talbot CountyCity or town Centon, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Memorial Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Queen Anne's Co.City or town Centerville

(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

De Rochefortne
Marion M. Miller

3. (b) Social Security Number

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Mrs. Marion Miller7. Birth date of deceased (mo., day, yr.) 1884 8. (c) If alive, give age 57 years8. AGE: Years 62 Months _____ Days _____ If less than one day _____ hrs. _____ min.9. Birthplace Hayden, 2 A. Co. Md.

(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

12. Name Robert Henry Miller13. Birthplace 2 A. Co. Md.14. Maiden name Adelaide Williamson15. Birthplace 2 A. Co. Md.16. Informant Mrs. Mary Bartlett MillerAddress Centerville Md17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof 3/11/46Cemetery or crematory ChesterfieldLocation Centerville Md.18. Funeral director Barton BrosAddress Centerville, Maryland.19. 3/9 46 N.H. Morris
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-8 1946, at 9 PM M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 8 1946, to March 8 1946 and that I last saw him alive on March 8 1946

Immediate cause of death _____

DURATION

1 neurosis in angitis 1 day

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE B. Co. Md M. D. or otherAddress East Md Date signed 3/10/46

RECEIVED
MAR 26 1946
BUREAU V.E.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (112)

02962

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:

County Talbot
City or town Belleveue
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? all of life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State MD County Talbot
City or town Belleveue
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2. (a) If veteran, name war

3. (a) FULL NAME

Agnes Douine Murray

3. (b) Social Security Number

4. Sex Female 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Single
6. (b) Name of husband or wife
7. Birth date of deceased (mo., day, yr.) April 27, 1945
8. AGE: Years 10 Months 4 Days 4 If less than one day
5. (c) If alive, give age years

9. Birthplace Belleveue, Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name William E. Murray

13. Birthplace Belleveue, Md.

14. Maiden name Agnes Melbourne

15. Birthplace Accomas, Va.

16. Informant Wm. E. Murray

Address Belleveue, Md.

17. Burial Date thereof Mar. 6th 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Luke's Church Cemetery

Location Belleveue, Md.

18. Funeral director John D. Williams

Address Exton, Md.

19. 3/6 46 N. H. Neirin
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 3, 1946 at 9:15 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 30 45 to Mar 3 46
and that I last saw him alive on Feb 25, 1946

Immediate cause of death Asphyxiation

Due to bronchial asthma

Due to cardiac embolism

Due to heart

Other conditions Rickets

(Include pregnancy within 8 months of death)

Major findings of operations None

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. Shivers

Address H. Thresholt

Date signed 3.6.46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 14 1948
BUREAU V.R.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02963

Reg. Dist. No. 290

1. PLACE OF DEATH:

County.....Talbot
 City or town.....Easton, Md
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Elmo Esau Ockimey

3. (b) Social Security Number

215-16-3983

4. Sex

Male

5. Color or race

Negro

6. (a) Single, married, widowed, or divorced

Mar

6. (b) Name of husband or wife

Stella Ockimey

7. Birth date of deceased (mo., day, yr.)

Apr. 10, 1886

8. (c) If alive, give age..... years

55

8. AGE:

Years

Months

Days

If less than one day

591114

hrs.

min.

9. Birthplace

Easton, Rural
(Town, county, and state)

10. Usual occupation

Laborer

11. Industry or business

MOTHER FATHER

12. Name

Jacob Ockimey

13. Birthplace

Easton Md rural

14. Maiden name

Charlotte Carter

15. Birthplace

Easton, Md, rural

16. Informant

James D Ockimey

Address

Easton, Md

17. Burial

(Burial, cremation, or removal, Which?)

Date thereof Mar 26 46
(month) (day) (year)

Cemetery or crematory

Unionville Md

Location

Easton, Rural, Md

18. Funeral director

John D Williams

Address

108 S. Harrison St Easton Md

19. 3/26

19 46

N. H. Reeves

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....Maryland County.....TalbotCity or town.....Easton

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2. (a) If veteran, name war.....

MEDICAL CERTIFICATION

2D. DATE OF DEATH Mar. 24, 1946 at 5:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....19....., to.....19.....

and that I last saw h.....alive on.....19.....

Immediate cause of death

Acute alcoholism

DURATION

1 day

Due to.....

Due to.....

Other conditions

Essential hypertension

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State).....

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE

Lois P. Neely MD Dep. Med Ex

M. D. or other

Address.....Easton Md Date signed 3-24-46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

WEST VIRGINIA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED

MAR 29 1946

BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 02964 290

1. PLACE OF DEATH:

County Garret
City or town Easton, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Easton Memorial Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Garret
City or town Grappe
(If outside city or town limits, write RURAL and give nearest town)
Street No. Rural
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

VIOLA BUSH ROBERTS

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
6. (b) Name of husband or wife Alfred R. Roberts
7. Birth date of deceased (mo., day, yr.) January 30, 1897 6. (c) If alive, give age 46 years
8. AGE: Years 49 Months 1 Days 13 If less than one day hrs. min.

9. Birthplace Lindsay, Ontario
(Town, county, and state)

10. Usual occupation Lady

11. Industry or business None

12. Name John J. Bush

13. Birthplace Canada

14. Maiden name Amy De Page

15. Birthplace Canada

16. Informant Mr. Alfred R. Roberts

Address Grappe, Md.

17. Funeral Date thereof March 16, 1946
(Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematorium Belmont Farm Funeral Home

Location Grappe, Md.

18. Funeral director W. L. Clark, M.D.

Address Easton, Md.

19. 3/14 19 46 N. L. Neer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 13, 1946 at 5:10 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 25, 1946 to March 13, 1946 and that I last saw him alive on March 13, 1946

Immediate cause of death Anaplasia

Due to Uterine Prolapse

Due to Uterine Prolapse

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Antepartum results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE M. V. Palmer

Address Easton, Maryland Date signed 3/18/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 26 1946

BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

CERTIFICATE OF DEATH

 02965 890
 Reg. Dist. No.

1. PLACE OF DEATH:

County BelletCity or town Eastern

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

115 West St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County TalbotCity or town Eastern R.D. #1

(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

3. (b) Social Security Number

Ross

4. Sex

F

5. Color or race

C

6.(a) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife _____

6.(c) If alive, give age _____ years

7. Birth date of

deceased (mo., day, yr.)

March 22, 1946

8. AGE:

Years

Months

Days

If less than one day

hrs. 10 min.

9. Birthplace

Eastern md.

(Town, county, and state)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name

Percy Ross

13. Birthplace

Ridge Oak md

14. Maiden name

Mary Wilson

15. Birthplace

New Chapel md.

16. Informant

Anna Floyd

Address

Eastern md.

17.

(Burial, cremation, or removal, which?)

Date thereof

3/22/46

Cemetery or crematory

Patterson Field

Location

Eastern md.

18. Funeral director

Percy Ross

Address

Eastern md.

19.

(Date rec'd by registrar)

3/22/46Rd. Harris

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 22 1946, at 4:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

_____ 19____ to _____ 19____

and that I last saw him _____ alive on _____ 19____

Immediate cause of death

Pneumonia

DURATION

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____

Injured at work? _____

23. SIGNATURE

N. H. Harris, Local Reg

M. D. or other

Address

EasternDate signed 3/22/46

RECEIVED

MAR 26 1946

BUREAU 78

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:

County Talbot
 City or town Easton
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 14 years
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Md. County Talbot
 City or town Easton
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war.

3. (a) FULL NAME

Mary C. Rowe

3. (b) Social Security Number

None

4. Sex Female 5. Color or race white 6. (a) Single, married, widowed, or divorced widowed

6. (b) Name of husband or wife James Rowe

7. Birth date of deceased (mo., day, yr.) Apr. 15, 1859 8. (c) If alive, give age 86 years

8. AGE: Years 86 Months 10 Days 18 If less than one day
 hrs. min.

9. Birthplace St. Marys Co., Md.
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name George R. Cheseldine

13. Birthplace St. Marys Co., Md.

14. Maiden name Mary H. Hewnott

15. Birthplace St. Marys Co., Md.

16. Informant M. E. Newman & Son
 Address Easton, Md.

17. Burial Date thereof Mar. 8, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Dudleville

Location Dudleville, Md.

18. Funeral director Maurice E. Newman & Son

Address Easton, Md.

19. 3/7 19 46 N. H. Newins
 (Date recd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 5 19 46, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 41 to Mar 5 19 46
 and that I last saw him alive on Mar 2 19 46

Immediate cause of death Myocardial infarction

Due to Chronic Myocarditis

Due to Essential hypertension

Other conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
 Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. Edgar Bowen M.D.
 M. D. or other

Address Easton Date signed 3-7-46

RECEIVED

MAR 14 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (940)

02967

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:

County..... Eastern
 City or town..... Easton
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... Life
 Hospital, institution, or street address where death occurred..... Memorial Hospital
 How long in hospital or institution?..... 3 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... Maryland County..... Salbot
 City or town..... Easton
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... Bay St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

JAMES SMITH

3. (b) Social Security Number

213-14-7588

4. Sex..... Male 5. Color or race..... White 6.(a) Single, married, widowed, or divorced..... Widowed
 6.(b) Name of husband or wife..... Cliff. Sarah Smith
 6.(c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.)..... July 2, 1870
 8. AGE: Years..... 75 Months..... 8 Days..... 0 If less than one day..... hrs. min.

9. Birthplace..... Salbot Co. Md.
(Town, county, and state)10. Usual occupation..... Carpenter

11. Industry or business.....

12. Name..... James Smith13. Birthplace..... Maryland14. Maiden name..... Maria Thompson15. Birthplace..... Maryland16. Informant..... Mrs. Maria ThompsonAddress..... Easton, Md.17. (Burial, cremation, or removal) Which?..... Burial Date thereof..... Mar. 5, 1946
(month) (day) (year)Cemetery or crematorium..... Spring HillLocation..... Easton, Md.18. Funeral director..... R. B. ParkAddress..... Easton, Md.19. 3/4..... 46..... N.H. Neeris
(Date rec'd by registrar) (year) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... March 2..... 19..... 46..... at..... 5:30 P...... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from..... March 2..... 19..... 46..... to..... March 2..... 19..... 46.....
 and that I last saw him..... alive on..... March 2..... 19..... 46.....

Immediate cause of death.....

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... Disg. verified by S.K.B.

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... R. B. Park..... M. D. or otherAddress..... Easton 2nd..... Date signed..... 3-4-46

RECEIVED
MAR 14 1946
BUREAU T F

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 822

CERTIFICATE OF DEATH

02968

★ Reg. Dist. No. 290

1. PLACE OF DEATH:

County Talbot
 City or town Easton
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 4 years
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Talbot
 City or town Easton
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Rural
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

GEORGE STEVENS

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White Widowed

6. (b) Name of husband or wife 6. (c) If alive, give age

Hannie B. Stevens

7. Birth date of deceased (mo., day, yr.) 8. (c) If alive, give age

August 7, 1868

8. AGE: Years Months Days If less than one day

77 7 20 hrs. min.

9. Birthplace

Talbot County, Md.
(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

12. Name

Joseph Stevens

13. Birthplace

Maryland

14. Maiden name

Sarah Mullikin

15. Birthplace

Maryland

16. Informant

Mrs. William Howell

Address

Easton, Md.

17. (Burial, cremation, or removal. Which?) Date thereof

Burial March 29, 1946
(month) (day) (year)

Cemetery or crematory

Spring Hill

Location

Easton, Md.

18. Funeral director

J. Edgar Clark

Address

Easton, Md.

19. (Date rec'd by registrar)

3/29 1946 N.H. Neuman Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 27 1946 at 1 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

December 1936 to March 1946

and that I last saw him alive on March 27, 1946

Immediate cause of death Cerebral thrombosis DURATION

1 week

Due to Arterio Sclerosis 10 yrs.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE William S. Seymour

Address Easton, Md. Date signed 3/28/46

RECEIVED

APR 4 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:

County TALBOT
 City or town MATHEWSTOWN, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 40
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Talbot
 City or town Mathewstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

ROBERT HENRY TEATS.

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

MALE C SINGLE

B. (b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.) MAR. 4, 1889

8. AGE: Years 56 Months - Days 2 It less than one day _____ hrs. _____ min.

9. Birthplace QUEEN ANNAS COUNTY.
 (Town, county, and state)

10. Usual occupation FARM LABOR.11. Industry or business STEVEN HENRY TEATS.12. Name A13. Birthplace QUEEN ANNA COUNTY.14. Maiden name GEORGE ANNA SIMONS15. Birthplace QUEEN ANNA COUNTY.16. Informant PEARL TEATS.Address EASTON, Md R.D. #317. BURIAL Date thereof MAR. 9, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory NEW CHAPEL CEMETERYLocation EASTON, Md. TALBOT CO.18. Funeral director Carl W. Stoddard.Address Coston, Md.

19. 3/7 46 H.H. Neeris
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 6 1946, at 2:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 1945 to March 6 1946
 and that I last saw him alive on March 4 1946

Immediate cause of death Carcinoma of the
Stomach DURATION 6 m.

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, till in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Karl Lederer M.D. M. D. or other

Address Queen Annez Md Date signed 3/8

RECEIVED
MAR 14 1946
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 980

CERTIFICATE OF DEATH

Reg. Dist. No. 1291

1. PLACE OF DEATH:

County Talbot
 City or town Royal Oak Md
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 4 hrs.
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State New York County Kings
 City or town New York City
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 223 Spring Ave Brooklyn
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Arthur S. Thomas
 4. Sex male 5. Color or race colored 6.(a) Single, married, widowed, or divorced widowed

3. (b) Social Security Number

221-09-3923

6.(b) Name of husband or wife

Lucille Thomas
 6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 9, 1886

8. AGE: Years 59 Months 10 Days 25 It less than one day
 hrs. min.

9. Birthplace Royal Oak Talbot Co. Md
 (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER 12. Name Joseph Thomas

13. Birthplace Royal Oak Md

MOTHER 14. Maiden name Henrietta Fields

15. Birthplace Royal Oak Md

16. Informant Alfred Thomas

Address Royal Oak Md

17. Burial Date thereof Mar 7, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Cemetery

Location Royal Oak Md

18. Funeral director Newnam & Harrison

Address St Michaels Md.

19. March 6 19 46 John Newnam
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 5 19 46 at 9 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 5 19 46 to March 5 19 46 and that I last saw him alive on March 5 19 46

Immediate cause of death Acute Myocarditis DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Hayward T. Webb M.D. M. D. or other

Address London, Md. Date signed 3/6/46

UNITED STATES DEPARTMENT OF HEALTH

STATE OF NEW YORK

OFFICE OF THE ATTORNEY GENERAL

ALBANY, N. Y.

RECEIVED

MAR 12 1946

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 742

02971

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH

County TalbotCity or town Easton
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 21 years

Hospital, institution, or street address where death occurred:

147 S. Washington St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County TalbotCity or town Easton
(If outside city or town limits, write RURAL and give nearest town)Street No. 147 S. Washington St.

(If rural, give LOCATION)

2.(a) If veteran, name war Spanish American

3. (a) FULL NAME

JAMES FREDERICK WALLACE

3. (b) Social Security Number

219-14-3644

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Blanche Love Wallace

7. Birth date of

deceased (mo., day, yr.)

June 29, 1872

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

73810

hrs.

min.

9. Birthplace

Dorchester County Md.

(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

Clothing Salesman

FATHER

12. Name

Wingate Wallace

13. Birthplace

Maryland

MOTHER

14. Maiden name

Katherine Andrews

15. Birthplace

Maryland

18. Informant

Mrs. J. F. Wallace

Address

Easton, Md.

17.

(Burial, cremation, or removal, Which?)

Burial

Date thereof

(month) (day) (year)

March 12, 1946

Cemetery or crematory

Spring Hill

Location

Easton, Md.

18. Funeral director

J. Cecil Clark DMS.

Address

Easton, Md.

19.

(Date rec'd by registrar)

3/13

19.

4H. H. Neerive

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9 19 46 at 12:45 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 8 19 46, to March 9 19 46and that I last saw him alive on March 9 19 46Immediate cause of death Coronary Thrombosis

DURATION

24 hrs.

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. V. Palmer

M. D. or other

Address Easton, Maryland Date signed 3/9/46

RECEIVED

MAR 20 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 291

1. PLACE OF DEATH:

County Talbot Co.City or town St. Michael's Md
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 68

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County TalbotCity or town St Michael's
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2(a) If veteran, name war _____

3. (a) FULL NAME

Ella Virginia Watkins

3. (b) Social Security Number

none4. Sex female5. Color or race white6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife J. Edward Watkins6. (c) If alive, give age 90 years7. Birth date of deceased (mo., day, yr.) Jan. 6, 18588. AGE: Years 88 Months 2 Days 15 If less than one day _____ hrs. _____ min.9. Birthplace Mc. Daniel Talbot Co, Md
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name John Wesley Mc. Daniel13. Birthplace McDaniel14. Maiden name Anna Knighton Mc. Daniel15. Birthplace McDaniel16. Informant Mrs. Sidney ChenAddress St. Michael's. Md17. Burial Date thereof Mar. 22, 1946
(Burial, cremation, or removal, which?) (month) (day) (year)Cemetery or crematory Christ CemeteryLocation St. Michael's. Md18. Funeral director Newman & HarrisonAddress St. Michael's. Md19. Book 22 19 46 John H. H. H. H.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 20 19 46 at 8 a.m.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 15 19 46 to Mar. 20 19 46.and that I last saw him alive on Mar. 19, 1946 19 _____Immediate cause of death Cerebralhemorrhage causingparalysisDue to arterio-sclerosis

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE S. Penny Willson M. D. or otherAddress St. Michael's Md Date signed Mar. 20 46

UNITED STATES DEPARTMENT OF JUSTICE

CERTIFICATE OF DEATH

STATE OF NEW YORK

DATE OF DEATH

DECEASED

RECEIVED

APR 3 1946

BUREAU V E

RECEIVED FOR RECORDS

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH: County <u>Talbot</u> City or town <u>Easton, Maryland</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? Hospital, institution, or street address where death occurred: <u>Memorial Hospital, Easton, Md.</u> How long in hospital or institution? <u>33 days</u>		2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State <u>Maryland</u> County <u>Talbot</u> City or town <u>Claiborne</u> (If outside city or town limits, write RURAL and give nearest town) Street No. _____ (If rural, give LOCATION) 2.(a) If veteran, name war _____	
3. (a) FULL NAME <u>Harry Yerby</u>		3. (b) Social Security Number _____	
4. Sex <u>M</u>	5. Color or race <u>W</u>	6. (a) Single, married, widowed, or divorced <u>M</u>	
6. (b) Name of husband or wife <u>Edna R. Yerby</u>		6. (c) If alive, give age <u>55</u> years	
7. Birth date of deceased (mo., day, yr.) <u>June 17 - 1881</u>			
8. AGE: Years <u>64</u> Months <u>9</u> Days <u>11</u>	If less than one day _____ hrs. _____ min.		
9. Birthplace <u>Whitestone, Va.</u> (Town, county, and state)			
10. Usual occupation <u>Merchant</u>			
11. Industry or business _____			
FATHER	12. Name <u>Joseph T. Yerby</u>		
	13. Birthplace <u>England</u>		
MOTHER	14. Maiden name <u>Shabellie Ingram</u>		
	15. Birthplace <u>Kilmarnock, Va.</u>		
16. Informant <u>Mrs. Harry P. Yerby</u> Address <u>Charlottesville, Md.</u>			
17. <u>Burial</u> Date thereof <u>Mar. 30, 1946</u> (Burial, cremation, or removal. Which?) (month) (day) (year) Cemetery or crematory <u>Wood Lawn</u> Location <u>Baltimore, Md.</u>			
18. Funeral director <u>Freeman & Harrison</u> Address <u>St. Michaels, Md.</u>			
19. <u>3/30</u> 19 <u>46</u> <u>D. H. Harris</u> (Date rec'd by registrar) Registrar			
MEDICAL CERTIFICATION 20. DATE OF DEATH <u>March 28, 1946</u> at <u>10⁰⁴ a.m.</u> 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>February 22, 1946</u> to <u>March 28, 1946</u> and that I last saw him alive on <u>March 28, 1946</u> Immediate cause of death <u>Pulmonary infarction</u> DURATION _____ Due to <u>Coronary thromboses</u> _____ Due to <u>Obstructive Cardiac disease</u> _____ Other conditions <u>Diabetes mellitus</u> _____ <u>Hemiplegia - left</u> (Include pregnancy within 3 months of death) Major findings of operations _____ Date of op. _____ Autopsy results _____ PHYSICIAN: Please underline the cause to which death should be charged statistically. 22. VIOLENCE: If death was due to external causes, fill in the following; Accident, suicide, or homicide _____ Date of _____ Where did injury occur? _____ (City or town) _____ (County) _____ (State) Injured at home, farm, industry, public place (where?) _____ Means of injury _____ Injured at work? _____ 23. SIGNATURE <u>M. V. Palmer</u> M.D. Address <u>Easton, Maryland</u> Date signed <u>3/30/46</u>			

